DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-5246
EMAIL: Medical@state.sd.us
WEB: dss.sd.gov

DSS
Strong Families - South Dakota's Foundation and Our Future

Out Of State Provider Enrollment Application

Date:_____

According to 42 CFR Section 431.52, States may pay out of state providers if the medical services are needed because of a medical emergency or if the medical services are needed and the recipient's health would be endangered if he/she were required to travel to his/her State of residence for the same service. To enroll in the South Dakota Medical Assistance Program as a Medicaid provider, this application must be completed. It contains questions to be answered completely and indicates other required documentation which must be submitted with enrollment forms. Please send documentation of the medical emergency (claim for services will be acceptable) or the endangerment of the recipient's health along with your application.

Provider Name:_____

Facility Name:_____

Please check all that apply: _____**New Enrollment**

_____**Reinstate** _____**Reinstate Date**

_____**Federal Tax ID Number Change**

1. Are you currently enrolled in your State's Medicaid program? _____YES _____NO

   If YES, what is your Medicaid Provider Number?_____

2. What is your Medicare number?_____

3. National Provider Identification (NPI) Number

   What is your Individual NPI number? _____

   What is the Billing NPI number (if applicable)? _____

   Address Location_____

4. Taxonomy Codes. When enrolling an individual provider at multiple service locations, with the same zip code and same individual and billing NPI number, South Dakota Medical Assistance requires an unique taxonomy code designated for that service location. This taxonomy code must be indicated on the claim form along with the individual NPI number and must match the data as shown on the provider file for that specific service location. What is the unique taxonomy code for specific service location (if applicable)?

   Code: _____ Service Location:_____

5. What is the Federal Tax Identification Name and Number (TIN) used for billing purposes?

   _____

6. What is your provider type and specialty (i.e. physician, internal medicine / hospital, psychiatric)?

   _____

7. Where will the medical services be provided (i.e. hospital, clinic, school, rehab facility)?

   _____

8. Are you employed or under contract by this facility type? _____YES _____NO
(attach copy of contract - i.e. CRNA's & physical therapists)

9. Do you repackage for unit dose for Long Term Care recipients (for pharmacy providers only)?
_____YES _____NO

10. What is your NCPDP Number (for pharmacy providers only)?_____

11. What is your CLIA number (for laboratories only)?_____

12. Do you wish to participate as a Primary Care Provider in the South Dakota Medical Assistance Program? _____YES _____NO If so, an Addendum to the contractual Provider Agreement must be completed. Contact our office for more information or visit our web site as noted on Page 1.

13 What is the service location name, address, and phone number?
Name:_____
Address:_____
City-State-Zip:_____
Phone Number:_____
Fax Number:_____
Contact Person:_____E-mail_____

14. What is the "pay to" location (address where payment will be sent)?
Name:_____
Address:_____
City-State-Zip:_____
Phone Number:_____
Fax Number:_____
Contact Person:_____E-mail_____

15. What is the billing location? Will you bill/process claims for enrolling provider? _____
Name:_____
Address:_____
City-State-Zip:_____
Phone Number:_____
Fax Number:_____
Contact Person:_____E-mail_____

16. When does billing location fiscal year end?_____

Also enclosed is the *South Dakota Medical Assistance Program Provider Agreement*. Please complete, sign, and return the agreement and this application along with requested information/documentation to:

Provider Enrollment
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Attach claim(s) indicating the date(s) services were provided to the South Dakota Medicaid Recipient. Please enclose a copy of all current licensure applicable showing expiration date and current W-9 (revised 11-2005).

If the agreement is for an individual, that person needs to sign as 'Authorized Signature'. If the agreement is for a facility, the Director, Administrator, CEO or CFO must sign as 'Authorized Signature'. A stamped provider's signature or office manager's signature is not acceptable. An original signature is required.

Upon receipt of all necessary information, a determination will be made regarding your qualifications as a provider under the South Dakota Medical Assistance Program. When a determination has been made, notification will be sent along with a copy of the approved provider agreement for your files.